ROLLINS SCHOOL OF PUBLIC HEALTH

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EMORY

March 21, 2007

Pete Stark
Chairman Ways and Means Subcommitee on Health
239 Cannon House Office Building
Washington, DC 20515

Dear Chairman Stark:

Thank you for your March 20, 2007 letter asking me to clarify the implications of my work on Medicare Advantage enrollment and more specifically on policy changes to the Medicare Advantage payment rates.

My most recent work for the Blue Cross Blue Shield Association (dated September 20, 2005) was a descriptive piece examining the characteristics of Medicare beneficiaries that select Medicare only, Medigap and Medicare+Choice plans (now Medicare Advantage). By itself, the paper does not comment on the policy choices involving the Medicare Advantage payment rates. The paper is purely descriptive in nature. The major conclusions in that paper were that beneficiaries not Medicaid eligible, and do not have access to employer-sponsored insurance, 53% of Hispanics and 40% of African-Americans selected Medicare+Choice plans. Both are higher proportions than selected Medigap and for Hispanics Medicare+Choice was the most popular of the three choices (Medicare only, Medicare+Choice, Medigap). The paper also examined enrollment trends by education and income.

The Medicare Prescription Drug,Improvement, and Modernization Act of 2003, Public Law 108-173 provided for several new plans including regional preferred provider organizations (PPO)s and special needs plans. The legislation also added a fourth category for determining increases in payments to MA plans (in addition to a blend, floor or 2% it added a projected increase in fee-for-setvice Medicare costs (excluding direct medical education and including a VA/DoD adjustment). This fourth category was designed to increase payments to MA plans, and with it the expectation of higher enrollment. As a result of the change, payments to MA plans have increased from approximately 107% of fee-for-service costs in 2004 compared to 112% today according to Medpac. The increased spending in the program has resulted in an increase in supplemental benefits, and with it an increase in enrollment. Today over 7.4 million Medicare beneficiaries are enrolled in MA plans---about the same share as the program's peak in 1999.

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I now turn to address your specific questions.

1. *Does your analysis on the participation rates of minorities in MA plans include any specific recommendations regarding MA payment rate policy?*

The short answer is no. We simply examine the demographic characteristics of Medicare beneficiaries that enrolled in Medicare only, purchased a medigap plan, or enrolled in Medicare+Choice (our original analysis used the most recent data we had—2003).

2. *Can your work in this area be fairly and accurately portrayed to mean that you oppose any reductions in payment rates to private plans?*

My work is really just descriptive and my views of changes in payment policy are not addressed in this work. I will address prospective policy changes in the MA program below.

3. *Do you believe there are appropriate savings to be achieved from the elimination of the stabilization fund and from equitable payment rates to PFFS plans?*

These are both areas that make sense for Congress to examine closely for potential savings. The stabilization fund was established to provide plans with incentives to remain in MA regions. It is not currently being used, and would be a fruitful area for achieving savings. My preference would be to use any savings from the fund (about $3.5 Billion over the next 10 years) to reinvest in health care.

With respect to PFFS, their payment rates were increased by Congress to create more opportunities for rural beneficiaries to join plans with augmented benefits (like their more suburban and urban counterparts). However, PFFS plans also receive among the highest payments relative to fee-for-service. Moreover, they do not perform care coordination—a critical direction the Medicare program needs to address more systemically. Properly balanced, a more equitable alignment of PFFS payments with the remaining portion of the MA program seems reasonable.

4. *Would any such reforms to the stabilization fund and PFFS plans have a detrimental and disproportionate impact on minorities?*

Our analysis relied on 2003 data, and did not specifically include either PPOs or PFFS plans. My sense is given their geographic locations (Wisconsin for instance) the impact on minority populations may be small. To my knowledge, though, we have little, if any, information on the demographics of who enrolls in these plans.

5. *Are there any savings to be achieved in MA plans that are worthy of consideration, and is there a balance policy makers should strive for?*

There are several areas that would be worthy of exploration—I have already noted two, the elimination of the stabilization fund, and aligning PFFS payments with rates ultimately paid to HMOs in the program. Reductions in payments to HMOs could generate substantial savings. Under one scenario examined by the CBO, paying MA plans at 100% of local fee-for-service rates would generate nearly $65 Billion in savings between 2008 and 2012.Any reductions in payments to HMOs in particular should balance the trade-offs. On the one hand, there are substantial savings to be achieved. On the other hand, reduced payments will lead to fewer supplemental benefits and less enrollment in the plans. Changes in plan payments implemented under the BBA of 1997 are illustrative of the potential impacts of these policy changes (in this case, payments to most plans were capped at 2% during a time of high cost growth)—enrollment declined from 6.9 million in 1999 to 5.5 million by 2002 and 5.3 million by 2003. These reductions, however, contributed toward the move to balance the budget.

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March 12, 2007

Alissa Fox
Vice President, Legislative and Regulatory Policy
Blue Cross and Blue Shield Association
1310 G Street, NW
Washington, DC 20016

Dear Alissa:

You asked me to estimate the impact of potential Congressional proposals to cut funding for Medicare Advantage (MA) by limiting payments to county-level costs under traditional Medicare. This letter includes some of the preliminary findings from a forthcoming paper that will assess the impact of such changes on Medicare Advantage enrollees.

Medicare beneficiaries join Medicare Advantage plans because they provide lower cost-sharing and additional benefits compared to those in traditional Medicare. Setting Medicare Advantage payments at the level of county costs under traditional Medicare would result in a reduction in benefits and cause enrollment in Medicare Advantage to decline.

Our model predicts reductions in Medicare Advantage enrollment that are similar – though potentially larger – than those observed in the period following enactment of the 1997 Balanced Budget Act, which limited payment increases to only 2 percent for most plans during a period of high medical cost inflation. During this period, nearly two million beneficiaries lost their health plan coverage. Preliminary findings from the research indicate that:

- **Three million MA enrollees – roughly one-third of current MA members – would lose MA coverage** due to increases in premiums, reductions in benefits, or withdrawal of their MA plan.
- **More than one million of those who would lose coverage would go without any additional coverage.** These beneficiaries would face higher cost-sharing and fewer benefits than they currently receive with their MA plan.

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As my previous research has indicated, Medicare Advantage plays a critical role in providing affordable coverage to low-income and minority beneficiaries. The program is particularly important for low-income beneficiaries, because it provides protection against the high cost-sharing in traditional Medicare. My 2005 research on this topic found the following:

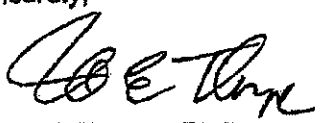
- **Medicare Advantage disproportionately covers low-income beneficiaries:** 35.6% of Medicare eligible beneficiaries with incomes below $10,000 annually and 37.8% of those with incomes from $10,000 to $20,000 without Medicaid or employer coverage enroll in Medicare Advantage plans.

- **Medicare Advantage serves a high proportion of minority beneficiaries:** 40% of African American and 52.9% of Hispanic beneficiaries without Medicaid or employer coverage rely on Medicare Advantage, as compared with 32.7% of non-Hispanic, white beneficiaries.

My forthcoming paper will evaluate in greater detail how proposed cuts will impact minority and low-income beneficiaries and reduce geographic access to Medicare Advantage plans.

The Medicare Modernization Act provided additional funding to Medicare Advantage to stabilize the program and expand its geographic access. This additional funding has increased the dollar value of supplemental benefits relative to those offered prior to the MMA. While reducing MA funding could generate savings to the government, these savings would come at the expense of reduced benefits for MA enrollees and loss of coverage options, particularly in rural areas.

Sincerely,



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